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IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1974

No. 74-8

J. B. O'CONNOR, M.D.,
Petitioner,

-v-

KENNETH DONALDSON,
Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEAL FOR THE FIFTH CIRCUIT

REPLY BRIEF FOR THE PETITIONER

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SUBJECT INDEX

Page

Facts..... 1

Argument..... 3

Conclusion.....24

Appendix

CITATIONS

Cases: Page

Briscoe v. Kusper,
435 F.2d 1046, 1057-58
(5th Cir. 1970).....21

Collins v. Schoonfield,
363 F.Supp. 1152, 1156
(D.Md. 1973).....20

Doe v. McMillian,
412 U.S. 306, 320 (1973).....16, 22

In re Donaldson,
364 U.S. 808 (1960).....18

Donaldson v. Florida,
371 U.S. 806 (1962).....18

Donaldson v. O'Connor,
390 U.S. 971 (1968).....18

Donaldson v. O'Connor,
234 So.2d 114 (Fla. 1969),
cert. den., 400 U.S. 869 (1970)...18

Eslinger v. Thomas,
476 F.2d 225, 229 (4th Cir. 1973).20

Gaffney v. Silk,
488 F.2d 1248, 1250
(1st Cir. 1973).....16

Handverger v. Harvell,
479 F.2d 513, 516 (9th Cir.),
cert. den., 414 U.S. 1972 (1973)..22

Harrison v. Brooks,
446 F.2d 404, 407 (1st Cir. 1971).22

Heines v. Kerner,
492 F.2d 937, 941
(7th Cir. 1974.....20

Hoffman v. Halden,
268 F.2d 280 at 301 (9th Cir. 1959).11

Jackson v. Indiana,
406 U.S. 715 (1972).....6

Jannetta v. Cole,
493 F.2d 1334, 1338
(4th Cir. 1974).....21

Jones v. Parrigan,
459 F.2d 81, 83 (6th Cir. 1972)...22

Mitchell v. Boslow,
357 F.Supp. 199, 202-203
(D.Md. 1973).....22

Pierson v. Ray, 15, 18
386 U.S. 547 (1967).....20
386 U.S. at 557.....15

Roberts v. Williams,
456 F.2d 819, 831 (5th Cir.),
cert. den., 404 U.S. 866 (1971)...16

Scheuer v. Rhodes,
416 U.S. 232 (1974).....15

Schmidt v. Wingo,
499 F.2d 70 (6th Cir. 1974),
affirming 368 F.Supp. 727 (W.D.
Ky. 1973).....22

Silber v. United States,
370 U.S. 717, 718 (1962).....24

Smith v. Losee,
485 F.2d 334, 342 (10th Cir. 1973)
(en banc).....22

Solesbee v. Balkom,
390 U.S. 9, 24-25 (1950).....10

Strickland v. Inlow,
485 F.2d 186, 191 (8th Cir. 1973),
cert. granted sub nom......21

United States v. Atkinson,
297 U.S. 157, 160 (1936).....24

Westberry v. Fisher,
309 F.Supp. 12, 17 (D.Me. 1970)...18

Wood v. Strickland, cert granted,
94 S.Ct. 1932 (No. 73-1285, 17,
Apr. 15, 1974).....21

Wyatt v. Aderholt,
503 F.2d 1305 (5th Cir. 1974).....11

Wyatt v. Stickney,
325 F.Supp. 781.....19

People ex rel. Anonymous v.
LaBurt, 14 App.Div. 2d 560,
218 N.Y.S.2d 738 (1961),
appeal dismissed and cert.
denied, 369 U.S. 428 (1962).....18

Florida Statutes:

§394.459.....5

§394.459(2)(4).....4

§394.459(13).....4

§394.467.....4, 5

Law Reviews, Books and Articles:

American Psychiatric Association
Position Statement on the Question of Adequacy of Treatment, 123 Am.J.Psychiat 1458, 1459 (1967).....8

Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960).....18

Ennis and Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 Cal.L.Rev. 693 (1974).....8, 9

Friedman and Kaplan, *The Comprehensive Textbook of Psychiatry*, p. 1436 (1967).....8

Roberts, *Some Observations on the Problems of the Forensic Psychiatrist*, 1965 Wis.L.Rev. 240, 244 (1965).....8

FACTS

The only important factual dispute that has arisen on appeal concerns whether the evidence supported the jury finding of dangerous. This issue should actually be irrelvant because dangerousness was not the sole criterion for commitment in Florida from 1957-1971 (A 243-256).

There was conflicting evidence at trial of Donaldson's propensity for violence. (A 3, 64-72, 81, 120-121, 131-133, 136, 149-150, 188(b), 196(a), 22[illegible], 232, 233, 235, 241(a)). Petitioner O'Connor firmly believed, in his professional opinion, that Donaldson was dangerous. Others disagreed.

Petitioner believes that the issue of psychiatric diagnosis of dangerousness should not have been subjected to jury review. Leading articles such as Ennis and Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 Cal.L.Rev. 693 (1974), teach us that psychiatrists cannot be expected to accurately predict dangerous behavior:

> One psychiatrist has noted that there is no emperical support for the belief that psychiatrists can predict dangerous behavior. To the contrary, even with the most careful, painstaking, laborious and lengthy clinical approach to the prediction of dangerousness, false positives may be a minimum of 60 to 70%. In other words,

> even under controlled conditions, at least 60 to 70% of the people whom psychiatrists judge to be dangerous may, in fact, be harmless. 62 Cal.L.Rev. 693 at 714.

The record shows little concrete evidence of dangerous behavior of Kenneth Donaldson during his hospitalization and might be said to support the jury verdict. However, in light of documented statistics which demonstrate the fallibility of psychiatric opinions of dangerousness, should Dr. O'Connor be made to answer in damages for the excercise of his professional judgment on that issue? Petitioner submits that the jury should not have been presented with this issue and that regardless of whether Donaldson was dangerous or not, he should not have been made to answer in damages for a decision made in the day-to-day exercise of his professional judgment.

I.

THE PROPOSED CONSTITUTIONAL RIGHT TO TREATMENT IS INCAPABLE OF ADEQUATE DEFINITION AND EFFECTIVE APPLICATION.

Petitioner does not quarrel with the proposition that persons involuntarily civilly committed to a state mental hospital are entitled to adequate treatment. However, the constitutional right to treatment, as stated by the Court of Appeals for the Fifth Circuit is a futile right incapable of definition or application which would adequately protect a patient who would seek to enforce it. At the same time, the right, as declared by the Court of Appeals, places an unreasonably heavy burden upon the attending physicians and hospital administrators who must answer for their day-by-day diagnostic and course-of-treatment decisions. Petitioner does not argue that the treatment decisions of psychiatrists should never be subject to judicial review, but does argue that the effect of the decision of the Court of Appeals is to allow the federal courts to subject psychiatric decisions to far greater scrutiny than is possible given the amorphous nature of psychiatry.

As discussed at oral argument, the State of Florida adopted a new mental health law in 1972, known as the Baker Act. Although the new statutory provisions are not at issue in this case, the Baker Act is set out in the Appendix of this Reply Brief for convenience of the Court.[1] Florida, by

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[1] R.A. at 1.

adoption of the Baker Act, implemented a sweeping declaration of patient rights, including a statutory right to treatment[2] which guarantees quality treatment suited to the needs of the individual patient. A hearing examiner conducts a periodic review of each patient's need for hospitalization and treatment.[3] Finally, a section of the Baker Act provides for monetary liability of any person who wilfully violates or abuses the statutory rights or privileges of patients, providing, however, immunity from liability for one who acts in good faith during his actions in connection with the admission, diagnosis, treatment or discharge of a patient.[4]

The new Florida Statutory scheme notwithstanding, Petitioner would argue that the step from a recognition of a right to treatment to a *constitutional* right to treatment is a step which must traverse a wide chasm, that chasm being a definition of what constitutes adequate treatment within the meaning of the proposed right, and the lack of guidelines for enforcement of the right by the federal judiciary.

It has been argued by Respondent that Petitioner's argument that the proposed constitutional right is non-justiciable must fail because the Florida Legislature

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2 §394.459(2)(4), Florida Statutes; RA at 8-9.

3 §394.467, Florida Statutes; RA at 20.

4 §394.459(13), Florida Statutes; RA at 12.

has established a definable statutory right to treatment, as discussed above. Respondent's argument in that regard has a ring of validity until one examines the scope of review as envisioned by the Florida Legislature as compared to that available under the holding of the Court of Appeals in this case. Section 394.459, Florida Statutes,[5] provides for a right to skillful quality treatment suited to the needs of the patient, and requires patient consent to treatment. The scope of review is impliedly limited to whether, as suggested by Respondent at page seventy of his Brief, the treatment in question lies "within a professionally accepted range of treatment modes."[6] On the other hand, the decision of the Court of Appeals goes far beyond the standards suggested by Respondent and implies that a federal court may order that some treatment modes are improper or ineffective and require an alternate course of treatment. Such judicial discretion removes treatment decisions from trained psychiatrists and places them upon the shoulders of a federal judge and/or jury. Petitioner is concerned by the prospect of federal courts doing as the Court of Appeals did when it declared that "mileau therapy", a professionally accepted

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5 RA at 8.

6 §394.467, Florida Statutes; RA at 20-26.

treatment mode, is but an evasive response used by doctors to avoid accusations of inadequate treatment, citing a law review article by a lawyer as authority.[7] Such judicial encroachment into professional decisions is not only improper but has the effect of placing any psychiatrist henceforth employing "mileau therapy" in an unnecessarily vulnerable position. Thus, the Court of Appeals has not limited the review of the federal judiciary to the question of whether professionally permissable care was provided, but has allowed a more intensive, utterly unacceptable, review of the desirability of one permissable treatment mode over another.

Petitioner argues that the right as stated by the Court of Appeals must fail, not because mental patients are not entitled to treatment, but because a *constitutional* right to treatment absent adequate judicial guidelines is a right incapable of meaningful, just enforcement. Such a right cannot truly be a right at all.

Petitioner accepts and agrees with this Court's view in *Jackson v. Indiana*, 406 U.S. 715 (1972), that the nature and duration of confinement must bear some reasonable relation to the purpose for which the person is committed. Petitioner further agrees that if there is a constitutional right to treatment, that it is not an express right but must flow from the due process clause of the Fourteenth Amendment.

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[7] 493 F.2d at 511.

Assuming there is a constitutional right there, its application must involve two separate inquiries. First, the commitment process must be examined for elements of due process. Second, there must be an investigation of whether the patient is receiving treatment appropriate to his disorder. If both inquiries are answered in the affirmative, requirements of due process should be satisfied. The Court of Appeals envisioned a far broader inquiry into whether the patient was receiving the best possible treatment rather than permissable treatment.

If we apply the above rationale to Donaldson's case, we find that there is little question that Donaldson was ill at the time of his commitment and that the statutory commitment procedures were followed. Donaldson's commitment complied with all requirements of due process under 1957 standards. We must then proceed to examine his treatment. Petitioner submits that Donaldson received all treatment available at Florida State Hospital, which was appropriate to his disorder, and to which he would submit.[8]

The right to treatment as announced by the Court of Appeals demonstrates the difficulty of enforcement when it comes time to review the treatment

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[8] A at 25, 37-38, 52, 75-76, 95-96, 114-115, 118, 122-126, 145, 152, 166, 195, 199, 200, 200(a), 201(a)(ii), 202(i), 202(b), 202(c), 203(a), 203(i), 204, 204(a), 204(b), 205-206(i).

rendered an individual patient. A bewildering number of variables must be considered when judging any patients treatment. These must include, at the least, consideration of: (1) the wide variety of psychiatric schools of thought and treatment;[9] (2) the inexac nature of psychiatry and psychiatric testimony;[10] patient cooperation;[11] and the nature of the disease.[12] The Court of Appeals left little room for many of these considerations. Yet all of these are crucial to the determination of whether a particular patient has received proper treatment.

Respondent argues that expert testimony of psychiatrists should be adequate to judge treatment. However, other sources, including an article written by Respondent's counsel, demonstrate that the science of psychiatry is far from exact and too

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9 Roberts, *Some Observations on the Problems of the Forensic Psychiatrist*, 1965 Wis.L.Rev. 240, 244 (1965).

10 Ennis and Litwack, *Psychiatry and te Presumption of Expertise: Flipping Coins in the Courtroom*, 62 Cal.L.Rev. 693 (174).

11 American Psychiatric Association, *Position Statement on the Question of Adequacy of Treatment*, 123 Am.J.Psychiat 1458, 1459 (1967).

12 Friedman and Kaplan, *The Comprehensive Textbook of Psychiatry*, p. 136 (1967).

unreliable to be of benefit as expert testimony in the courtroom.[13] The Ennis and Litwack article suggests that diagnostic decisions of psychiatrists disagree at an alarming rate:

> Actually, as we shall see, the reliability of psychiatric judgments of specific diagnostic categories (schizophrenia, paranoid type, depressive reaction, passive-agressive personality, and so on) is even lower--somewhere in the neighborhood of 40 percent. In other words, if a first psychiatrist testifies that a prospective patient suffers from involuntary melancholia or some other specific, non-organic diagnosis, it is more likely than not that a second psychiatrist would disagree.[14]

Ennis and Litwack note further that psychiatric predictions of success of a particular treatment mode are equally unreliable:

> Robbins and Guze surveyed the literature concerning the validity of clinician's judgments of the prognosis of schizophrenic patients. They found considerable variations between the predicted prognosis and the actual outcomes of treatment. In practice, patients who received a poor prognosis did poorly as

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13 Ennis and Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 Cal.L.Rev. 693 (1974).

14 62 Cal.L.Rev. 693 at 702.

> infrequently as 55 percent of the time in one study and as frequently as 91 percent of the time in another. In contrast, patients with a good prognosis did well as frequently as 83 percent of the time in one study and as infrequently as 36 percent in another.
>
> Other investigations showed that psychiatrists accurately predicted the beneficial or nonbeneficial effect of electro-shock therapy for several hundred patients only 41 percent of the time. In other words, their predictions would have been more valid if they had been based on the flip of a coin.[15]

Faced with such statistics it is difficult to imagine allowing a federal court jury to evaluate treatment and punish a psychiatrist for having failed in prescribing a more successful course of treatment. Psychiatry remains a science of "tentative and dubious knowledge as to mental disease "with" great strife in schools in regard to them" as noted by Justice Frankfurter in *Solesbee v. Balkom*, 339 U.S. 9, 24-25 (1950). Justice Frankfurter's concern over the "treacherous uncertainties in the present state of psychiatric knowledge" should guide this Court to the realization that the very nature of psychiatry prohibits enforcement of a *constitutional* right to treatment on the individual level as in this case.

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15 62 Cal.L.Rev. 693 at 719.

While enforcement of the proposed right may be impossible on the individual level, enforcement of a general right to treatment on the institutional level, such as in *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974), may have similar difficulties. Such enforcement does not guarantee adequate treatment on the individual level and solve the problems of this case; the institutional course does guarantee a more adequate level of care to all patients.

II.

DR. O'CONNOR SHOULD NOT HAVE BEEN FOUND TO BE PERSONALLY LIABLE FOR HIS DECISIONS NOT TO RELEASE DONALDSON.

It has been argued by Respondent that Dr. O'Connor was properly held liable for a series of refusals to restore Respondent Kenneth Donaldson to his liberty "either by treatment or release."

Petitioner submits that he was entitled to immunity for his quasi-judicial decisions not to release Kenneth Donaldson, a patient committed by judicial order. Dr. O'Connor's decisions not to release Kenneth Donaldson must be considered to have been of a quasi-judicial nature. This theory was raised before the trial court, is not new to the law, and was the basis of the decision in *Hoffman v. Halden*, 268 F.2d 280 at 301 (9th Cir. 1959). This theory was, however, rejected by the Court of Appeals when raised by a co-Appellant, Dr. Gumanis.

In the alternative, Petitioner submits that the doctrine of good-faith should have been applied to insulate him from liability. This defense was raised before the trial court. However, the trial court rejected Petitioner's requested jury instruction and gave an instruction written by the Court (A 184-85):

> Now, the Defendants in this action have claimed and are relying on the defense that they acted in good faith. Simply put, the Defendants contend they in good faith believed it was necessary to detain Plaintiff in the Florida State Hospital for treatment for the length of time he was so confined.
>
> If the Jury should believe from a preponderance of the evidence that the Defendants reasonably believed in good faith that detention of Plaintiff was proper for the length of time he was so confined then a verdict for Defendants should be entered even though the Jury may find the detention to have been unlawful.
>
> However, mere good intentions which do not give rise to a reasonable belief that detention is lawfully required cannot justify Plaintiff's confinement in the Florida State Hospital.
>
> As a corollary Plaintiff here need not show malice or ill-will to prove his action under the Civil Rights Act. All that is required is that he demonstrate state action which amounts to an actual deprivation of constitutional rights or other rights guaranteed by law.
>
> As to this defense of good faith, the burden is upon the Defendants to prove this defense by a preponderance or a greater weight of the evidence in the case. (e.s.)

Although this instruction was never objected to by Petitioner's counsel at trial, it is clearly a very misleading and improper instruction. It seems to say that good faith is a defense, but is not a defense. The confusing effect of such wording on the jury can be easily imagined.

The jury instruction aside, the evidence cannot be read to demonstrate bad faith on Dr. O'Connor's part. Dr. O'Connor relied heavily upon staff opinion, and the record reflects that decisions to refuse release were not Dr. O'Connor's alone. The staff conference of April 2, 1962, shows four doctors in agreement. (A 194). The conference report of January 9, 1964, shows similar agreement (A 195), as does that of March 21, 1968, with the exception that the staff recommended trial visits or out-of-state release (A 197). Dr. O'Connor is clear from aspersions of bad faith or malice in regard to decisions not to grant the recommended trial visits or out-of-state release. The record shows Donaldson had repeatedly refused trial

visits (A 152), and out-of-state release was considered inappropriate. (A 131, 164). Psychological testing, when not refused by Donaldson, (A 234), showed a similar consensus of opinion that Donaldson was ill and should not be released (A 230-241(a)). An exception to that series was the final test which ultimately lead to Donaldson's release.

The opinion of an outside psychologist, Dr. Calhoun, also supported Dr. O'Connor's actions. (A 222). Dr. O'Connor's judgment was further vindicated by the refusal of the state and federal courts to order Donaldson's release on some fifteen to twenty occasions from 1957 to 1970. Available information on several of those cases is contained in the Appendix to this Reply Brief, as requested by Mr. Justice Blackmun.

Dr. O'Connor's testimony, by depositions and interrogatories, supports the view that he relied on the reports of Donaldson's attending physicians and consensus of staff opinion (A 127, 129, 130, 131, 132, 133, 134, 136, 137, 165, 166, 169, 170).

The Court should also consider the evidence concerning inadequate staffing of Florida State Hospital during the time period in question. The record shows that the case loads were fifteen times heavier than current American Psychiatric Association standards. In addition, the physicians were required to spend nearly one-half of their time on administrative duties, leaving an average of two minutes per patient per

week for treatment, observation, etc. However, the record further shows Dr. O'Connor's efforts during his tenure as Superintendent to improve care and conditions. (A 167-69).

Respondent also points to Dr. O'Connor's occasional denials of such things as grounds privileges but conveniently overlooks evidence that grounds privileges were rejected because Donaldson had on one occasion attempted to escape from the hospital. (A 118, 127).

Further evidence of Dr. O'Connor's good-faith treatment comes from the mouth of Respondent who testified that he believed that Dr. O'Connor respected his belief in Christian Science and that Dr. O'Connor had told him that he would not be forced to accept medication unless he became a behavior problem. (A 52).

This Court has emphasized repeatedly that state officials should not be liable personally for damages when they have acted in good faith in the performance of their duties. In *Pierson v. Ray*, 386 U.S. 547 (1967), the Court held that plaintiffs could not recover damages from individual police officers for an unconstitutional arrest "if the jury found that the officers reasonably believed in good faith that the arrest was constitutional." *Id.* at 557. Similarly, this Court in *Scheuer v. Rhodes*, 416 U.S. 232 (1974), made clear that this "qualified immunity" not only extends to more senior state officials, but in fact should be broader

as the defendant's "scope of discretion and responsibilities" is broader. *Id.* at 247. *See also Doe v. McMillian*, 412 U.S. 306, 320 (1973).

The official immunity doctrine "seeks to reconcile two important considerations--

> '[O]n the one hand, the protection of the individual citizen against pecuniary damage caused by oppressive or malicious action on the part of [government officials]; and on the other, the protection of the public interest by shielding responsible governmental officers against the harassment and inevitable hazards of vindictive or ill-founded damage suits brought on account of action taken in exercise of their official responsibilities.'" [*Doe v. McMillan*, *supra*, 412 U.S. at 319, *quoting* *Barr v. Matteo*, 360 U.S. 564, 565 (1959).]

One court has summarized the doctrine as allowing "a qualified immunity based on good faith performance of duty as the officials understood it." *Roberts v. Williams*, 456 F.2d 819, 831 (5th Cir.), *cert. denied*, 404 U.S. 866 (1971); *accord*, *e.g.*, *Gaffney v. Silk*, 488 F.2d 1248, 1250 (1st Cir. 1973). Thus, the defense consists of two basic elements. First, courts must focus on the official's understanding of his or her duty; the courts will consider the defense in light of that understanding, so long as it is reasonable, even if

incorrect. The second element[17] of the defense provides immunity when the official made a good faith effort to meet that duty, as so understood, even if the effort was unsuccessful.

Regarding the first part of the defense, the law is well settled that a state official should not be held personally liable for a civil rights violation when he or she had tried in good faith to follow then-existing constitutional principles, even

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[17] In a case where the definition of defendant's legal duty is clear, only the latter element of the defense is relevant. In the instant case, however, where the constitutional contours of the duty are still developing, the two elements are interrelated. Thus, defendant's good faith effort must be measured against whatever legal duty he reasonably should have know was applicable. The question of whether an objective or subjective standard is appropriate in assessing whether a defendant made such a "good faith effort" is now pending before the Court in *Wood v. Strickland*, *cert. granted*, 94 S.Ct. 1932 (No. 73-1285, Apr. 15, 1974).

if those principles later were overturned. As this Court held in *Pierson v. Ray*, *supra*, 386 U.S. at 557, state officers are not "charged with predicting the future course of constitutional law." They "neither can nor should be expected to be seers in the crystal ball of constitutional doctrine." *Westberry v. Fisher*, 309 F.Supp. 12, 17 (D.Me. 1970).

In the instant case, a constitutional right to treatment was little more than a gleam in the eye of its most ardent proponent during Mr. Donaldson's confinement, which began in 1957. The article generally credited as the first even to suggest such a right appeared in 1960. Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960); *see* 493 F.2d at 519-20 & nn.12, 14. Several courts during the 1960's refused to recognize the existence of a constitutional right to treatment. *See, e.g., People ex rel. Anonymous v. LaBurt*, 14 App.Div. 2d 560, 218 N.Y.S.2d 738 (1961), *appeal dismissed and cert. denied*, 369 U.S. 428 (1962). Indeed, Mr. Donaldson himself brought several earlier right-to-treatment claims against Dr. O'Connor, and the courts consistently rejected these claims. *See, e.g., Donaldson v. O'Connor*, 234 So.2d 114 (Fla. 1969), *cert. denied*, 400 U.S. 869 (1970). *See also Donaldson v. O'Connor*, 390 U.S. 971 (1968); *Donaldson v. Florida*, 371 U.S. 806 (1962); *In re Donaldson*, 364 U.S. 808 (1960). It was not until 1971, the year of Mr. Donaldson's release from Chattahoochee, that the first court held that there was a constitutional

right to treatment. *Wyatt v. Stickney*, *supra*, 325 F.Supp. 781.

Not only is the constitutional right to treatment a recent development, but the past decade has also seen major changes in the professional approach toward psychiatric treatment of the seriously mentally ill. Beginning in the 1960's psychiatrists began to recognize that long-term custodial care of the mentally ill, in large and dehumanizing institutions situated in isolated settings, was often counterproductive and therefore should be resisted. Many patients--even those with the most serious mental illness (such as that diagnosed in Mr. Donaldson's case)--could be rapidly returned to home and community. This approach was made possible in part by the advent of effective medications which moderated the symptoms and allowed patients to be managed in the community.

With or without such medications the fundamental approach to most of these patients has now been modified, and every attempt is made to return them to home, family, work, and community as soon as possible.

Mr. Donaldson was originally hospitalized at a time when the community mental health approach had not been clearly formulated or generally accepted. Much of the testimony given in his case assumes the general acceptance of the community mental health approach without recognizing the changes which were occurring in psychiatry during that period.

Thus, not only was Dr. O'Connor judged by a new legal standard, but also his approach to treatment was measured in terms of a new psychiatric perspective.

Under these circumstances it is unfair and contrary to the principle this Court stated in *Pierson v. Ray* to apply the right-to-treatment principle retroactively by holding psychiatrists personally liable for damages dating back many years before they could have known of this new constitutional duty.

Respondent argues that this issue was never raised below. Petitioner must disagree. The issue was raised in pre-trial motion practice, through Defendants proposed Jury Instruction No. 15 which was denied, and in a Post-Argument Memorandum filed at the request of the Court of Appeals. Other Circuits have recognized the necessity of "providing conscientious state officials with some protection against the cutting edge of a rapidly developing legal doctrine."[18]

As stated in *Collins v. Schoonfield*, 363 F.Supp. 1152, 1156 (D.Md. 1973), "it would contravene basic motions of fundamental fairness if officials were held to be liable monetarily for acts which they could not reasonably have known were unlawful."

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18 *Eslinger v. Thomas*, 476 F.2d 225, 229 (4th Cir. 1973); *Heines v. Kerner*, 492 F.2d 937, 941 (7th Cir. 1974).

Equitable relief, of course, should always be available to insure compliance with newly developing legal standards. *See Jannetta v. Cole*, 493 F.2d 1334, 1338 (4th Cir. 1974):

> ...while there is nothing in §1983 or the fourteenth amendment to suggest that an improper motive is requisite for a federal cause of action, conscientious state officials, when acting reasonably and in good faith, should not be expected to answer in money damages for failure to accurately predict the future course of constitutional doctrine, even though such failure may entitle a plaintiff to equitable relief.

See also Briscoe v. Kusper, 435 F.2d 1046, 1057-58 (7th Cir. 1970). Thus, the good faith defense in no way defines the right; it simply limits the remedy to equitable relief and to damages against the institution or officials who have not acted in good faith.

The second element of the good faith defense that should be available in cases such as this would forbid personal liability whenever the doctor makes a good faith, even if unsuccessful, effort to meet the duty he or she reasonably understands is owed to the patient. Numerous courts have applied this qualified immunity principle to a wide variety of official positions. *See, e.g., Strickland v. Inlow*, 485 F.2d 186, 191 (8th Cir. 1973), *cert. granted sub nom. Wood v. Strickland*, 94 S.Ct. 1932 (No. 73-1285,

Apr. 15, 1974)(school board members); *Handverger v. Harvill*, 479 F.2d 513, 516 (9th Cir.), *cert. denied*, 414 U.S. 1072 (1973)(university officials); *Jones v. Perrigan*, 459 F.2d 81, 83 (6th Cir. 1972)(FBI agent); *Harrison v. Brooks*, 446 F.2d 404, 407 (1st Cir. 1971)(town officials); *Mitchell v. Boslow*, 357 F.Supp. 199, 202-203 (D.Md. 1973)(director of state institution for "defective delinquents"). The principle is at least equally applicable to staff psychiatrists and hospital officials, whose "scope of discretion and responsibilities" is necessarily broad, since they must make countless on-the-spot expert judgments each day in treating their patients. *See Doe v. McMillan*, *supra*, 412 U.S. at 320; *Smith v. Losee*, 485 F.2d 334, 342 (10th Cir. 1973)(en banc).

This good faith defense is particularly appropriate where, as here, fulfillment of defendant's duty is seriously hampered by thoroughly inadequate resources. All that can reasonably be asked in these circumstances is that the official make a good faith effort with the limited resources available. For example, in *Schmidt v. Wingo*, 499 F.2d 70 (6th Cir. 1974), *affirming* 368 F.Supp. 727 (W.D.Ky. 1973), plaintiff sought damages from the defendant prison warden, alleging that plaintiff's decedent, a prison inmate, died as a result of inadequate medical care furnished at the prison hospital. The court in *Schmidt* recognized that it would be both illogical and unjust "to place liability upon the Warden of a

penitentiary for the failure to furnish [adequate] equipment and personnel, where the budget for personnel and equipment are fixed by his superiors, the Department of Corrections and by the General Assembly of the State of Kentucky." 368 F.Supp. at 731; *see* 499 F.2d at 74.

Petitioner requests this Court to view this issue as it relates to state employed psychiatrists. Proper application of the good faith defense doctrine should immunize Petitioner from personal liability where, as in this case, if the evidence demonstrates overwhelmingly that he used his best efforts to treat Mr. Donaldson, who was, at best, a recalcitrant, uncooperative patient. Petitioner would caution the court that affirmance of the actions of the Court of Appeals would operate to elevate to constitutional demensions the myriad of day-to-day medical decisions that must be made by state employed psychiatrists. The picture of physicians afraid of liability for the act of prescribing a drug, altering a treatment plan, or acting on requests for privileges is not an attractive one.

Consonant with the above discussion of immunity, Petitioner believes that the evidence does not support the jury verdict in this case. The District Court should have granted the Motion for Directed Verdict made during trial. (A 140). Failing that, the District Court should have granted Petitioner's Motion for Judgment Notwithstanding the Verdict. Although this argument was not considered in depth in the Court of

Appeals, Petitioner believes that this Court may consider all aspects of the record and declare that the refusals of the District Court and the Court of Appeals to find in favor of Petitioner amounted to "plain error" reviewable in the absence of any objection by the parties.[19]

Conclusion

The theory of a constitutional right to treatment for civilly committed mental patients is a novel innovation in the law, but is one with which Petitioner agrees in spirit. However, the constitutional right to treatment as announced, without guidelines for enforcement, by the Court of Appeals for the Fifth Circuit cannot be allowed to exist as such. It is a fine statement of a moral right, but absent essential guidelines for recognition, definition, enforcement and implementation, it does not rise to the status of a legal right. It is among that class of obligations spoken to by Justice Holmes: "Legal obligations that exist but cannot be enforced are ghosts that are seen in the law but that are elusive to the grasp."[20]

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19 See, e.g., *Silber v. United States*, 370 U.S. 717, 718 (1962); *United States v. Atkinson*, 297 U.S. 157, 160 (1936).

20 *The Western Maid*, 257 U.S. 419, 433 (1922).

Accordingly, Petitioner requests this Court to view the issues of this case in a broad light. The legal issue of whether there exists a constitutional right to a certain level of treatment aside, Petitioner asks this Court to view the record independent of the jury verdict and findings of the Court of Appeals. Petitioner firmly believes that such an investigation will reveal that the evidence did not support the verdict rendered below.

Finally, Petitioner requests the Court to consider the propriety of the retroactive application of a recently established constitutional right, such as occurrred in this case.

For reasons set forth above, it is respectfully submitted that the judgment of the Court of Appeals should be reversed.

Respectfully submitted,

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REPLY BRIEF

APPENDIX

Chapter 394, Florida Statutes

PART I

FLORIDA MENTAL HEALTH ACT

394.451 Short title.
394.453 Legislative intent.
394.455 Definitions.
394.457 Operation and administration.
394.459 Rights of patients.
394.460 Rights of physicians.
394.461 Facilities; transfer of patients.
394.463 Admission for emergency or evaluation.
394.465 Voluntary admissions.
394.467 Involuntary hospitalization.
394.469 Discharge of patients.
394.471 Validity of prior hospitalization orders.
394.473 Attorneys' and physicians' fees.
394.475 Acceptance, examination, and involuntary hospitalization of Florida residents from out-of-state mental health authorities.
394.477 Residence requirements.
394.478 Autopsy of deceased patient.

394.451 Short title.—This part I of chapter 394 shall be known as "The Florida Mental Health Act" or "The Baker Act."

History.—§1, ch. 71-131.

394.453 Legislative intent.—It is the intent of the legislature to authorize and direct the department of health and rehabilitative services to evaluate, research, plan, and recommend to the governor and the legislature programs designed to reduce the occurrence, severity, duration, and disabling aspects of mental, emotional,

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and behavioral disorders. The department of health and rehabilitative services is directed to implement and administer programs through the division of mental health as authorized and approved by the legislature, based on the department's annual program budget. It is the further intent of the legislature that programs of the department shall coordinate the development, maintenance, and improvement of receiving and community treatment facilities within the programs of the district mental health boards as authorized by the community mental health act, part IV of this chapter. Treatment programs shall include, but not be limited to, comprehensive health, social, educational, and rehabilitative services to persons requiring intensive short term and continued treatment in order to encourage them to assume responsibility for their treatment and recovery. It is intended that patients shall be provided with emergency service and temporary detention for evaluation when required; that patients be admitted to treatment facilities on a voluntary basis when extended or continuing care is needed and unavailable in the community; that involuntary hospitalization be provided only when expert evaluation determines that it is necessary; and that individual dignity and human rights be guaranteed to all persons admitted to mental health facilities.

History.—s2, ch. 71-131.

394.455 Definitions.—As used in this part, unless the context clearly requires otherwise:

(1) "Hospital" means a public or private hospital or institution or part thereof licensed by the division of health of the department of health and rehabilitative services and equipped to provide inpatient care and treatment facilities, or any hospital under the supervision of the department.

(2) "Physician" means an individual licensed or authorized to practice medicine or osteopathy under the laws of Florida.

(3) "Mentally ill" means having a mental, emotional, or behavioral disorder which substantially impairs the person's mental health.

(4) "Department" means the department of health and rehabilitative services.

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(5) "Division" means the division of mental health of the department of health and rehabilitative services.

(6) "Secretary" means the secretary of the department of health and rehabilitative services.

(7) "Director" means the director of the division of mental health of the department of health and rehabilitative services.

(8) "Mental health board" means the board within a board district established in accordance with the provisions of the community mental health act, part IV of this chapter, for the purposes of administering the community mental health program.

(9) "Board district" means that area over which a single mental health board has jurisdiction for administering mental health programs as provided by the community mental health act, part IV of this chapter, and may consist of one or more services districts.

(10) "Facility" means any state-owned or state-operated hospital or state-aided community facility designated by the department to be utilized for the evaluation, diagnosis, care, treatment, training, or hospitalization of persons who are mentally ill, and any other hospital within the state approved and designated for such purpose by the department.

(11) "Community facility" means a facility which receives funds from the state under the community mental health act, part IV of this chapter.

(12) "Receiving facility" means a facility designated by the department to receive patients under emergency conditions or for psychiatric evaluation and to provide short-term treatment, and also means a private facility when rendering services to a private patient pursuant to the provisions of this act.

(13) "Treatment facility" means a state-owned, state-operated, or state-supported hospital, center, or clinic designated by the department for the treatment and hospitalization of persons who are mentally ill, including facilities of the United States government, and also

means a private facility when rendering services to a private patient pursuant to the provisions of this act. Patients treated in facilities of the United States government shall be solely those whose care is the responsibility of the Veterans' Administration.

(14) "Private facility" means any hospital or facility operated by a nonprofit corporation or association or a proprietary hospital approved by the department.

(15) "Patient" means any mentally ill person who seeks hospitalization under this part, or any person for whom such hospitalization is sought.

(16) "Administrator" means the chief administrative officer of a receiving or treatment facility or his designee.

(17) "Staff member" means an employee of a receiving or treatment facility who has been designated as a staff member by the department.

(18) "Law enforcement officer" means any city police officer, officer of the state highway patrol, sheriff, or deputy sheriff.

(19) "Guardian" means a natural guardian of a minor or a legal guardian appointed by a court to maintain custody and control of the person or of the property of an incompetent.

(20) "Representative" means a person appointed to receive notice of proceedings for and during hospitalization and to take actions for and on behalf of the patient.

(21) "Court," unless otherwise specified, means the circuit court.

(22) "Judge," unless otherwise specified, means the judge of the circuit court or the judge designated to act under this act by the chief judge of a circuit.

(23) "Clinical record" means all parts of the record required to be maintained and includes all medical records, progress notes, charts, admission and discharge data, and all other information recorded by a facility which pertains to the patient's hospitalization and treatment.

History.—§3, ch. 71-131; §1, ch. 72-356; §1, ch. 73-131; §25, ch. 73-334.

394.457 Operation and administration.—

(1) ADMINISTRATION.—The department, by and through the division of mental health, is designated the mental health authority of Florida. The department shall exercise executive and administrative supervision over all division facilities, programs, and services.

(2) RESPONSIBILITIES OF THE DEPARTMENT.—The department is responsible, through the division, for the planning, evaluation and coordination of a complete and comprehensive statewide program of mental health including community services, receiving and treatment facilities, child services, research, and training. The department is also responsible, through the division, for the implementation of programs and coordination of efforts with other departments and divisions of the state government, county and municipal governments, and private agencies concerned with and providing mental health services. It is responsible for establishing standards, providing technical assistance, and exercising supervision of mental health programs of state-supported community facilities and other facilities for the mentally ill. It shall stimulate research by public and private agencies, institutions of higher learning, and hospitals in the interest of the elimination and amelioration of mental illness.

(3) POWER TO CONTRACT.—The department, through the division, may contract to provide, and be provided with, services and facilities in order to carry out its responsibilities under this part with the following agencies: district mental health boards; public and private hospitals; clinics; laboratories; departments, divisions and other units of state government; the state colleges and universities; the community colleges; private colleges and universities; counties, municipalities, and any other governmental unit, including facilities of the United States government; and any other public or private entity which provides or needs facilities or services. Services contracted for by the division may be reimbursed by the state at a rate up to 100 percent. The department shall make periodic audits and inspections to assure that the contracted services are provided and meet the standards of the department.

(4) APPLICATION FOR AND ACCEPTANCE OF GIFTS AND GRANTS.—The department, through the division, may apply for, and accept any funds, grants, gifts, or services made available to it by any agency or department of the federal government or any other public or private agency or individual in aid of mental health programs. All such moneys shall be deposited in the state treasury and shall be disbursed as provided by law.

(5) RULES AND REGULATIONS; PERSONNEL.—

(a) The department shall adopt rules and regulations necessary for administration of this part in accordance with the administrative procedure act, chapter 120.

(b) The director of the division of mental health shall be qualified for the position by graduation from an accredited school of medicine and be licensed to practice medicine in at least one state and shall have sufficient training and experience in the field of psychiatry to meet the requirements for examination by the American Board of Psychiatry and Neurology, Inc., or be a qualified licensed practicing physician.

(c) The department shall, by regulation, establish standards of education and experience for professional and technical personnel employed in mental health programs.

(6) HEARING EXAMINERS.—

(a) One or more hearing examiners shall be appointed by the secretary to hold hearings for continued hospitalization. Such hearing examiners shall be members of The Florida Bar and shall be compensated by the department.

(b) In the conduct of hearings the hearing examiner shall have the authority to:

1. Administer oaths and affirmations;

2. Sign and issue subpoenas for the appearance of witnesses and production of documents required for the conduct of the hearing;

3. Rule on evidence;

4. Provide for the taking of testimony by deposition.

(c) If a subpoena issued by the hearing examiner is disobeyed, the hearing examiner may apply to the circuit court of the county in which the hearing is held for an order requiring compliance.

(d) An order of the hearing examiner shall be reviewable by the circuit court of the county in which the hearing is held.

(7) PAYMENT FOR CARE OF PATIENTS.—Fees for patients in treatment facilities shall be based on a fee schedule prepared and published by the department. Fees shall be collected by the division and be based on cost of care and ability to pay. An unpaid fee shall constitute a lien on the nonexempt property of the patient; however, payment of charges shall not be a prerequisite to treatment. Legal action for recovery of unpaid fees shall be brought by the department or by the department of legal affairs for the department.

(8) DESIGNATION OF TREATMENT FACILITIES.—Florida State Hospital located at Chattahoochee, Gadsden County; G. Pierce Wood Memorial Hospital located at Arcadia, DeSoto County; South Florida State Hospital located at Hollywood, Broward County; and Northeast Florida State Hospital located at Macclenny, Baker County; and such other facilities as may be established by law or designated by the department, including facilities of the United States government, if such designation is agreed to by the appropriate governing body or authority, are designated as treatment facilities.

(9) DESIGNATION OF APPROVED PRIVATE PSYCHIATRIC FACILITIES.—Private psychiatric facilities may be approved by the department to provide emergency admission, court-ordered evaluation, and treatment on an involuntary basis. Such facilities are authorized to act in the same capacity as receiving and treatment facilities and are subject to all the provisions of this part, except that patients shall have the right to a hearing for continued involuntary hospitalization every sixty days according to established hearing procedures set forth herein.

History.—§1, ch. 57-317; §1, ch. 59-222; §1, ch. 65-13; §4, ch. 65-22; §1, ch. 65-145; §1, ch. 67-334; §§11, 19, 31, 35, ch. 69-106; §4, ch. 71-131; §70, ch. 72-221; §2, ch. 72-396; §2, ch. 73-133; §25, ch. 75-191.

Note.—Formerly §§65.013; §402.10.

394.459 Rights of patients.—

(1) RIGHT TO INDIVIDUAL DIGNITY.—The policy of the state is that the individual dignity of the patient shall be respected at all times and upon all occasions, including any occasion when the patient is taken into custody, detained, or transported. Procedures, facilities, including jails, vehicles, and restraining devices utilized for criminals or those accused of crime shall not be used in connection with the noncriminal mentally ill except for the protection of the patient or others. If, in an emergency, a mentally ill person is placed in a jail, such a facility may be used only as long as the emergency exists and in no case longer than five days. Treatment shall be provided to the patient by his physician or the receiving facility staff. No person who is receiving treatment for mental illness in a hospital shall be deprived of any constitutional rights. However, if such a person is adjudicated incompetent pursuant to the provisions of this part, his rights may be limited to the same extent the rights of any incompetent person are limited by general law.

(2) RIGHT TO TREATMENT.—The policy of the state is that the department shall not deny treatment for mental illness to any person, and that no services shall be delayed at a receiving or treatment facility because of inability to pay.

(3) RIGHT TO INFORMED PATIENT CONSENT.—

(a) All patients entering a facility shall be asked to sign an "authorization for psychiatric treatment" form.

(b) In addition to the provisions of paragraph (a), in the case of surgical procedures requiring the use of a general anesthetic or electroconvulsive treatment, and prior to performing the procedure, written permission shall be obtained from the patient, if he is legally competent, from the parent or guardian of a minor patient, or from the guardian of an incompetent patient. The facility administrator or his designated representative may, with the concurrence of the patient's attending physician, authorize emergency surgical treatment if such treatment is deemed lifesaving and permission of the patient and his guardian or representative cannot be obtained.

(4) QUALITY OF TREATMENT.—

(a) Each patient in a facility shall receive treatment suited to his needs, which shall be administered skillfully, safely, and humanely with full respect for his dignity and personal integrity. Each patient shall receive such medical, vocational, social, educational, and rehabilitative services as his condition requires to bring about an early return to his community. In order to achieve this goal the department is directed to coordinate the programs of the division with all other divisions of the department.

(b) If a patient is able to secure the services of a private physician, he shall be allowed to see his physician at any reasonable time. In addition, any patient's attending physician may utilize the services of a consulting physician for the purpose of aiding in evaluation, diagnosis, and treatment. Such consultant may be reimbursed in a manner to be determined by the department within available funds, for services related to this act. The department shall establish regulations designed to facilitate examination and treatment by private physicians on a consulting basis.

(5) COMMUNICATION AND VISITS.—

(a) Each patient in a facility has the right to communicate freely and privately with persons outside the facility unless it is determined that such communication is likely to be harmful to the patient or others.

(b) Each patient shall be allowed to receive, send, and mail sealed, unopened correspondence, and no patient's incoming or outgoing correspondence shall be opened, delayed, held, or censored by the facility unless there is reason to believe that it contains items or substances which may be harmful to the patient or others, in which case the administrator may direct reasonable examination of such mail and may regulate the disposition of such items or substances.

(c) If a patient's right to communicate is restricted by the administrator, written notice of such restriction shall be served on the patient and his guardian or representatives, and such restriction shall be recorded on the patient's clinical record with the reasons therefor. The restriction of a patient's right to communicate shall be reviewed at least every ninety days.

(d) The department shall establish reasonable regulations governing visitors, visiting

hours, and the use of telephones by patients.

(6) CARE AND CUSTODY OF PERSONAL EFFECTS OF PATIENTS.—A patient's right to his clothing and personal effects shall be respected. The administrator may take temporary custody of such effects when required for medical and safety reasons. Custody of such personal effects shall be recorded in the patient's clinical record.

(7) VOTING IN PUBLIC ELECTIONS.—A patient in a facility who is eligible to vote according to the laws of the state has the right to vote in the primary and general elections. The department shall establish rules and regulations to enable patients to obtain voter registration forms, applications for absentee ballots, and absentee ballots.

(8) EDUCATION OF CHILDREN.—The department shall provide education and training appropriate to the needs of all children in treatment facilities.

(9) CLINICAL RECORD; CONFIDENTIALITY.—A clinical record for each patient shall be maintained. The record shall include data pertaining to admission and such other information as may be required under regulations of the department. Unless waived by the patient or his guardian or attorney, the privileged and confidential status of the clinical record shall not be lost by either authorized or unauthorized disclosure to any person, organization, or agency. The clinical record shall not be a public record and no part of it shall be released, except:

(a) The record may be released to physicians, attorneys, and government agencies as designated by the patient, his guardian or his attorney.

(b) The record shall be produced in response to a subpoena or released to persons authorized by order of court, excluding matters privileged by other provisions of law.

(c) The record or any part thereof may be disclosed to a qualified researcher, a staff member of the facility, or an employee of the department when the administrator of the facility or secretary of the department deems it necessary for treatment of the patient, maintenance of adequate records, compilation of treatment data, or evaluation of programs.

(d) Information from the clinical records may be used for statistical and research purposes if the information is abstracted in such a way as to protect the identity of individuals.

(10) HABEAS CORPUS.—

(a) At any time, and without notice, a person detained by a facility, or a relative, friend, guardian, representative, or attorney on behalf of such person, may petition for a writ of habeas corpus to question the cause and legality of such detention and request that the circuit court issue a writ for release. Each patient admitted to a facility for involuntary hospitalization shall receive a written notice of the right to petition for a writ of habeas corpus.

(b) A patient or his guardian or representatives may file a petition in the circuit court in the county where the patient is hospitalized alleging that the patient is being unjustly denied a right or privilege granted herein or that a procedure authorized herein is being abused. Upon the filing of such a petition, the circuit court shall have the authority to conduct a judicial inquiry and to issue any appropriate order to correct an abuse of the provisions of this part.

(11) TRANSPORTATION.—If neither the patient nor any person legally obligated or responsible for the patient is able to pay for the expense of transporting the patient to a treatment facility, the governing board of the county from which the patient is hospitalized shall arrange for such required transportation. The department shall promulgate rules and regulations to insure safe and dignified transportation for all patients.

(12) DESIGNATION OF REPRESENTATIVES; NOTICE OF ADMISSION.—

(a) At the time a patient is admitted to a facility, the names and addresses of two representatives or one guardian shall be entered in the patient's clinical record.

1. A treatment facility shall give written notice of the patient's admission to his guardian or representatives.

2. A receiving facility shall give notice of admission to the patient's guardian or representatives by telephone or in person within twenty-four hours.

(b) If the patient has no guardian, he may designate one representative; the second representative, or both in the absence of designation of one representative by the patient, shall be selected by the facility. The first representative selected by the facility shall be made from the following in the order of listing:

1. The patient's spouse;
2. An adult child;
3. Parent;
4. Adult next of kin;
5. Adult friend; or
6. The division of family services.

The second representative selected by the facility shall be without regard to the order of listing. If the facility can locate only one person from the categories listed above, it shall only be required to select one representative.

(c) Unless otherwise provided, notice to the patient's guardian or representatives shall be served by registered or certified mail, and the date on which such notice was mailed shall be entered on the patient's clinical record.

(13) LIABILITY FOR VIOLATIONS.—Any person who violates or abuses any rights or privileges of patients provided by this act shall be liable for damages as determined by law. Any person who acts in good faith in compliance with the provisions of this part shall be immune from civil or criminal liability for his actions in connection with the admission, diagnosis, treatment, or discharge of a patient to or from a facility. However, this section shall not relieve any person from liability if such person is guilty of negligence.

History.—§5, ch. 71-131; §1, ch. 73-133; §25, ch. 73-331.

394.460 Rights of physicians.—No physician shall be required to accept patients for treatment of mental, emotional, or behavioral disorders. Such participation shall be voluntary.

History.—§4, ch. 73-133.

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394.461 Facilities; transfers of patients.—

(1) RECEIVING FACILITY.—The department, through the division, may designate any community facility as a receiving facility for emergency, short term treatment and evaluation. The governing board of any county is authorized to contract with the department or with the mental health board of a board district, with the approval of the department, to set aside an area of any facility of the department to function, and be designated, as the receiving facility. Any other facility within the state, including a federal facility, may be so designated by the department at the request of and with the consent of the governing officers of the facility.

(2) TREATMENT FACILITY.—Any state-owned, state-operated, or state-supported facility may be designated by the department as a treatment facility. Any other facility, including a federal facility, may be so designated by the department at the request of, or with the consent of, its governing officers.

(3) TRANSFERS OF PATIENTS.—

(a) Any patient who has been admitted to a treatment or receiving facility on a voluntary basis and is able to pay for treatment in a private facility may apply to the department for transfer at his expense to such private facility. A patient may apply to the department for transfer from a private facility to a public facility. An involuntary patient may be transferred at the discretion of the department or upon application by the patient or the guardian of said patient.

(b) When the medical needs of the patient or efficient utilization of the facilities of the department require, a patient may be transferred from one facility of the department to another or, with the consent of the patient and his guardian or representatives, to a facility in another state.

(c) When any patient is to be transferred, notice shall be given to his guardian or representatives prior to the transfer.

History.—§6, ch. 71-131; §3, ch. 72-396; §5, ch. 73-133.

394.463 Admission for emergency or evaluation.—

(1) EMERGENCY ADMISSION.—

(a) *Criteria.*—A person may be admitted to a receiving facility on emergency conditions if there is reason to believe that he is mentally ill and because of his illness is:

1. Likely to injure himself or others if allowed to remain at liberty, or

2. In need of care or treatment and lacks sufficient capacity to make a responsible application on his own behalf, and an ex parte order is obtained authorizing the admission.

(b) *Initiation of proceeding.*—An emergency admission may be initiated as follows:

1. A judge may enter an ex parte order stating that a person appears to meet the criteria for emergency admission, giving the findings on which that conclusion is based and directing that a law enforcement officer take the person into custody and deliver him to the nearest receiving facility for emergency examination and treatment. The order of the court shall be made a part of the patient's clinical record; or

2. A law enforcement officer may take a person who appears to meet the criteria for emergency admission into custody and deliver him to the nearest receiving facility for emergency examination and treatment. The officer shall execute a written report detailing the circumstances under which the person was taken into custody, and the report shall be made a part of the patient's clinical record; or

3. A physician may execute a certificate that he has examined a person within the preceding forty-eight hours and finds that the person appears to meet the criteria for emergency admission, stating the observations upon which that conclusion is based. The physician's certificate shall authorize a law enforcement officer to take the person into custody and deliver him to the nearest available receiving facility for emergency examination and treatment. The law enforcement officer shall execute a written report detailing the circumstances under which the person was taken into custody. The report and physician's certificate shall be made a part of the patient's clinical record.

(c) *Emergency examination.*—A patient who is admitted for an emergency examination and treatment by a receiving facility shall be examined by a physician without unnecessary delay, and may be given such treatment as is indicated by good medical practice.

(d) *Release of patient.*—At any time the examining physician concludes that the patient need not be hospitalized or that further evaluation is not necessary, the patient shall be discharged immediately unless the patient is under criminal charges, in which case he shall be returned to the custody of a law enforcement officer. The patient must be released within forty-eight hours of his admission except when the examining physician concludes that there is reason to believe that the patient may require evaluation or treatment, in which case, unless the patient voluntarily agrees to evaluation, treatment, or hospitalization, a proceeding for court-ordered evaluation or involuntary hospitalization shall be initiated.

(2) COURT-ORDERED EVALUATION.—

(a) *Criteria.*—A person may be admitted to, or retained in, a receiving facility for evaluation if there is reason to believe that he is mentally ill and because of his illness is:

1. Likely to injure himself or others if allowed to remain at liberty, or

2. In need of care or treatment and lacks sufficient capacity to make a responsible application on his own behalf.

(b) *Initiation of proceeding.*—A court-ordered evaluation may be initiated as follows:

1. Any person may file with the court a petition, executed under oath and supported by affidavits of two additional persons, requesting an evaluation of a person located in the county who is alleged to meet the criteria for a court-ordered evaluation; or

2. Any person may file with the court a petition executed under oath alleging that a person in the county meets the criteria for a court-ordered evaluation. The petition must be accompanied by the certificate of a physician stating that he has examined the patient within the preceding five days and has found that the patient may be mentally ill and in need of hospitalization and that a full evaluation is necessary.

(c) *Notice; hearing on petition.*—The judge shall set a hearing on the petition and shall serve notice of the time and place of such hearing on the patient, his guardian, if one has previously been appointed, and the person, if any, having custody and control of the patient. In the absence of a guardian, two other representatives for the service of the notice shall be designated by the court, one of whom, other than the person who filed the petition, shall be selected in the following order:

1. The patient's spouse;
2. An adult child;
3. Parent;
4. Adult next of kin;
5. Adult friend; or
6. The division of family services.

The second representative shall be selected from the above list without regard to the order of listing. The court shall make such efforts, as in its discretion it determines reasonable in view of the emergency, to contact the persons listed above in the order listed. The court shall notify any other person, including any persons whose names appear in the patient's court file, that the judge believes has a concern for the patient's welfare. The hearing shall be set within five days of the date of mailing the notice with a copy of the petition attached. The court shall grant a continuance upon application by the patient, his guardian, or a representative if such continuance is found necessary to permit preparation for the hearing. The hearing may be waived in writing by the patient. The patient and his guardian or representatives shall be informed of the right to counsel by the judge and, if the patient cannot afford an attorney to represent him at the hearing, the judge shall appoint one.

(d) *Order for evaluation.*—After a hearing or, if the hearing is waived, after a review of all evidence, if the judge is satisfied that immediate evaluation is necessary, he shall issue an

order to any law enforcement officer to deliver the patient to a receiving facility for evaluation. If the judge is satisfied that evaluation is necessary, but that the patient need not be hospitalized immediately for his own safety or that of others, he may order the patient to appear at a designated receiving facility at a specified time within three days. If the patient fails to appear at the specified time, the order of the court, countersigned by the administrator of the facility to show that the person did not appear as ordered, shall authorize and direct any law enforcement officer to take the person into custody and deliver him to the specified receiving facility.

(e) *Evaluation by a receiving facility.*—A patient who is admitted to a receiving facility may be detained for a period not to exceed five days. The staff members of all receiving facilities shall encourage patients to apply for voluntary hospitalization if hospitalization appears necessary. Within the five day evaluating period one of the following actions shall be taken:

1. The patient shall be released;
2. The patient shall be released for outpatient treatment by a community facility;
3. The patient shall agree to hospitalization as a voluntary patient; or
4. Proceedings for involuntary hospitalization shall be initiated.

Treatment shall be made available when determined by a receiving facility physician to be necessary.

(3) DISCHARGE OF PATIENT.—At any time the patient is found not to require hospitalization for emergency treatment or evaluation, the receiving facility shall discharge the patient unless the patient is under criminal charges, in which case he shall be returned to the custody of a law enforcement officer. Notice of the discharge shall be given to the patient's guardian or representatives, to any physician who executed a certificate admitting the patient to the receiving facility, and to any court which ordered the patient's evaluation.

History.—§7, ch. 71-131, §6, ch. 73-191.

394.465 Voluntary admissions.—

(1) AUTHORITY TO RECEIVE PATIENTS.—

(a) A facility may receive for observation, diagnosis, or treatment any individual eighteen years of age or older making application for admission or any individual between the ages of twelve through seventeen for whom such application is made by his parent or guardian. If found to show evidence of mental illness and to be suitable for treatment, such person may be admitted to the facility.

(b) A facility may admit for evaluation, diagnosis, or treatment any individual twelve years of age or older who makes application therefor. If such individual is under eighteen years of age, his parent or guardian may apply for his discharge, and the administrator shall release the patient within five days of such application for discharge.

(2) RIGHT OF VOLUNTARY PATIENTS TO DISCHARGE.—

(a) A facility shall discharge a voluntary patient who has sufficiently improved so that hospitalization is no longer desirable. A patient may also be discharged to the care of a community facility. A voluntary patient or his guardian, representative, or attorney may request discharge in writing at any time following admission to the facility. This request may be submitted to a member of the staff of the facility for transmittal to the administrator. If the patient, or another on his behalf, makes an oral request for release to a staff member, such request shall be immediately entered in the patient's clinical record, and the patient must within three days be given counseling and assistance in preparing a written request. If a written request is submitted to a staff member, it shall be delivered to the administrator within twenty-four hours. Within five days of delivery of a written request for release to the administrator, the patient must be discharged from the facility or a plan instituted for a discharge of the patient.

Such plan shall be approved by the patient. If discharge would be unsafe to the patient or others, proceedings for involuntary hospitalization must be initiated within three days of delivery of the written request. If the patient was admitted on his own application and the request for discharge is made by a person other than the patient, the discharge may be conditioned upon the agreement of the patient. If the patient is under the age of eighteen, his parent or guardian may act for him.

(b) If the administrator, upon the advice of the patient's attending physician, determines that the patient needs to be transferred to a long-term treatment facility and the patient refuses to go as a voluntary patient, the administrator shall be authorized to file a petition for involuntary hospitalization.

(3) NOTICE OF RIGHT TO RELEASE.—At the time of his admission and each six months thereafter, a voluntary patient and his guardian or representatives shall be notified in writing of his right to apply for a discharge.

(4) TRANSFER TO VOLUNTARY STATUS.—Staff members of all treatment facilities shall encourage an involuntary patient to transfer to voluntary status unless the patient is under criminal charge, or unless the patient is unable to understand the nature of voluntary hospitalization or unless voluntary hospitalization would be harmful to the patient, in which case a finding to this effect shall be entered in the patient's clinical record. Any involuntary patient who applies shall be transferred to voluntary status immediately, unless such transfer would not be in the best interest of the patient, in which case such finding shall be entered in the patient's clinical record and shall be subject to review every ninety days. When transfer to voluntary status occurs, notice shall

be given to the patient and his guardian or representatives and, if the patient is hospitalized under an order of court, to the court which entered such order.

(5) TRANSFER TO INVOLUNTARY STATUS.—A patient who has agreed to be hospitalized as a voluntary patient and, upon arrival at the treatment facility, refuses to remain as a voluntary patient may be detained by the treatment facility for a period not to exceed five days while the administrator of the treatment facility initiates procedures for involuntary hospitalization.

History.—§8, ch. 71-131; §7, ch. 73-133; §109, ch. 73-333.

394.467 Involuntary hospitalization.—

(1) CRITERIA.—A person may be involuntarily hospitalized if he is mentally ill and because of his illness is:

(a) Likely to injure himself or others if allowed to remain at liberty, or

(b) In need of care or treatment and lacks sufficient capacity to make a responsible application on his own behalf.

(2) ADMISSION TO A TREATMENT FACILITY.—A patient may be hospitalized in a treatment facility, after notice and hearing, upon recommendation of the administrator of a receiving facility where the patient has been admitted for examination or evaluation. When a patient is not an inpatient in a receiving facility, the administrator of a designated receiving facility may make a recommendation for involuntary hospitalization of a patient who has been given an examination, evaluation, or treatment by staff of the receiving facility or a private physician. The hearing may be waived in writing by the patient. The recommendation must be supported by the opinions of two physicians who have personally examined the patient within the preceding five days that the criteria for involuntary hospitalization are met. Such recommendation shall be entered on a hospitalization certificate, which certificate shall authorize the receiving facility to retain the patient pending

transfer to a treatment facility or completion of a hearing. The certificate shall be filed with the court in the county where the patient is located and shall serve as a petition for a hearing regarding involuntary hospitalization. *[A copy of] the certificate shall also be filed with the division, and copies shall be served on the patient and his guardian or representatives, accompanied by:

(a) A written notice, in plain and simple language, that the patient or his guardian or representative may apply at any time for a hearing on the issue of the patient's need for hospitalization if he has previously waived such a hearing.

(b) A petition for such hearing, which requires only the signature of the patient or his guardian or representative for completion.

(c) A written notice that the petition may be filed with a court in the county in which the patient is hospitalized at the time the certificate is executed and the name and address of the judge of such court.

(d) A written notice that the patient or his guardian or representative may apply immediately to the court to have an attorney appointed if the patient cannot afford one.

The petition may be filed in the county in which the patient is hospitalized at any time within six months of the date of the certificate. The hearing shall be held in the same county, and one of the patient's physicians at the hospital shall appear as a witness at the hearing. If the hearing is waived, the court shall order the patient to be transferred to a treatment facility or, if he is at a treatment facility, that he be retained there. However, the patient can be immediately transferred to the treatment facility by waiving his hearing without awaiting the court order. The hospitalization certificate shall serve as authorization for the patient to be transferred to a treatment facility and as authorization for the treatment facility to admit the patient. The treatment facility may retain a patient for a period not to exceed six months from the date of admission.

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If continued hospitalization is necessary at the end of that period, the administrator shall apply to the hearing examiner for an order authorizing continued hospitalization.

(3) PROCEDURE FOR HEARING ON HOSPITALIZATION.—

(a) If the patient does not waive a hearing or if the patient, his guardian, or a representative files a petition for a hearing after having waived it, the judge shall serve notice on the administrator of the facility in which the patient is hospitalized, and may serve notice on the state attorney of the judicial circuit of the county in which the patient is hospitalized, who shall represent the state. The court shall hold the hearing within five days unless a continuance is granted. The patient, his guardian or representative, or the administrator may apply for a change of venue for the convenience of parties or witnesses or because of the condition of the patient. Venue may be ordered changed within the discretion of the court. The patient and his guardian or representative shall be informed of the right to counsel by the court. If the patient cannot afford an attorney, the court shall appoint one. One of the physicians who executed the hospitalization certificate shall be a witness. If the court concludes that the patient meets the criteria for involuntary hospitalization, the judge shall order the patient to be transferred to a treatment facility, or, if he is at a treatment facility, that he be retained there, or to be treated at any other appropriate facility or service on an involuntary basis. The order shall adequately document the nature and extent of a patient's mental illness. The judge may adjudicate a person incompetent pursuant to the provisions of this act at the hearing on hospitalization. The treatment facility may accept and retain a patient admitted involuntarily for a period not to exceed six months whenever the patient

is accompanied by a court order and adequate documentation of the patient's mental illness. Such documentation shall include a psychiatric evaluation and any psychological and social work evaluations of the patient. If further hospitalization is necessary at the end of that period, the administrator shall apply to the hearing examiner for an order authorizing continued hospitalization.

(b) In the event a person is ordered into a treatment facility under the provisions of the Florida Rules of Criminal Procedure or chapter 801 or chapter 917, the order shall adequately document the nature and extent of a patient's mental illness. The treatment facility may accept and retain a patient so admitted for a period not to exceed six months whenever the patient is accompanied by a court order and adequate documentation of the patient's mental illness. Such documentation shall include a psychiatric evaluation and any psychological and social work evaluations of the patient and document the results of any criminal investigation on the patient. "[If] a patient is considered to be suffering from an emotional illness to the extent that he cannot participate in his own defense, such documentation should include details regarding the evaluation which led to that conclusion. If further hospitalization is necessary at the end of his authorized treatment period, the administrator shall apply to the hearing examiner for an order authorizing continued hospitalization.

(c) The court shall provide a court order, a psychiatric evaluation, and other adequate documentation of each patient's mental illness to the administrator of a treatment facility whenever a patient is ordered for involuntary hospitalization, whether by civil or criminal court. The administrator of a treatment facility may refuse admission to any patient directed to its facilities on an involuntary basis, whether by civil or by criminal court order, who is not accompanied at the same time by adequate orders and documentation.

(4) PROCEDURE FOR CONTINUED HOSPITALIZATION; HEARING EXAMINER.—

(a) If continued hospitalization of an involuntary patient is necessary, the administrator shall, prior to the expiration of the period during which the treatment facility is authorized to retain the patient, request an order authorizing continued hospitalization. This request shall be accompanied by a statement from the patient's physician justifying the request and a brief summary of the patient's treatment during the time he was hospitalized. In addition, the administrator shall submit an individualized plan for the patient for whom it is requesting continued hospitalization. Notification of this request for retention shall be mailed to the patient and his guardian or representative along with a completed petition, requiring only a signature, for a hearing regarding the continued hospitalization and a waiver of hearing form. The waiver of hearing form shall state that the patient is entitled to a hearing under the law; that he is entitled to be represented by an attorney at the hearing and, if he cannot afford an attorney, that one will be appointed; and that, if it is shown at the hearing that the patient does not meet the criteria for involuntary hospitalization, he is entitled to be released. If the patient or his guardian or representative does not sign the petition, or if the patient does not sign a waiver within fifteen days, the hearing examiner shall notice a hearing with regard to the patient involved within ten days after the expiration of the aforesaid period.

(b) Any time continued hospitalization is requested, the hearing examiner may, on his own motion, notice a hearing.

(c) Any time continued hospitalization is requested by the administrator, the administrator may request a hearing, and the hearing examiner shall hold a hearing within fifteen days of such request.

(d) The administrator shall not transfer any patient to voluntary status when he has reasonable cause to believe that the patient is dangerous to himself or others. In any case in which the administrator has reasonable cause to believe that an involuntary patient is dangerous to himself or others, the administrator shall request continued hospitalization. In any case in which a request for continued hospitalization is necessary, but the administrator after reviewing the case believes there is not reasonable cause to believe that the patient meets the criteria for involuntary hospitalization at the time of application for transfer to voluntary status and the patient needs continued hospitalization, the patient shall be transferred to a voluntary status.

(e) If the patient or his guardian or representative returns the signed petition noted in paragraph (a), the hearing examiner shall set a time and place for a hearing to be held within ten days of the time he receives the petition. A continuance not to exceed five days may be granted at the discretion of the hearing examiner. The patient and his guardian or representative shall be informed of the right to counsel by the hearing examiner. In the event a patient cannot afford counsel in a hearing before a hearing examiner, the public defender in the county where the hearing is to be held shall act as attorney for the patient.

(f) If the patient waives his hearing or if at a hearing it is shown that the patient continues to meet the criteria for involuntary hospitalization, the hearing examiner shall sign the order for continued hospitalization. The treatment facility shall be authorized to retain the patient for a period not to exceed one year. The same procedure shall be repeated prior to the expiration of each additional one-year period the patient is retained.

**(g) If continued hospitalization is neces-

sary for an individual admitted while serving a criminal sentence, but whose sentence is about to expire, or for an individual hospitalized while a minor, but who is about to reach the age of twenty-one, the administrator shall petition the hearing examiner for an order authorizing continued hospitalization.

History.—§9, ch. 71-131; §8, ch. 73-133.
*Note.—Bracketed words inserted by the editors.
**Note.—Ch. 73-21, Laws of Florida, removed the disability of nonage for persons 18 years of age and older.
Cf.—§1.01(14) Definition of minor.
§744.07 Rights, privileges and obligations of persons 18 years of age or older.
§744.31 Petition for appointment of guardian for a person mentally or physically incompetent.

394.469 Discharge of patients.—

(1) POWER TO DISCHARGE.—At any time a patient is found no longer to meet the criteria for involuntary hospitalization, the administrator may:

(a) Discharge the patient, unless the patient is under a criminal charge, in which case he shall be transferred to the custody of the appropriate law enforcement officer;

(b) Transfer the patient to voluntary status on his own authority or at the patient's request, unless the patient is under criminal charge; or

(c) Place an improved patient, except a patient under a criminal charge, on convalescent status in the care of a community facility.

(2) NOTICE.—Notice of discharge or transfer of status shall be given to the patient, his guardian or representatives, and, if the patient's hospitalization was by order of a court, the court which entered such order.

(3) CONVALESCENT STATUS; REHOSPITALIZATION.—An improved patient may be placed on convalescent status for a period of up to one year in the care of a community facility when such action is in the best interest of the patient. Notice of the patient's placement on

convalescent status shall be given to the patient and his guardian or representatives, to the community facility, and, if the patient's hospitalization was by order of a court, to the court which entered the order. Placement on convalescent status shall include provisions for continuing responsibility by a community facility, including a plan for treatment on an out-patient basis. The administrator of the treatment facility from which the patient is given convalescent status may, at any time during the continuance of such convalescent status, rehospitalize the patient when the condition of the patient requires. An involuntary patient may be rehospitalized for the remainder of his authorized treatment period, and the treatment facility shall have up to one additional month during which to apply for continued hospitalization.

History.—§10, ch. 71-131; §9, ch. 73-133.
Cf.—§744.31 Petition for appointment of guardian for a person mentally or physically incompetent.

394.471 Validity of prior hospitalization orders.—No hospitalization of a mentally ill person, lawful before January 1, 1972, shall be deemed unlawful because of the enactment of this part. The department shall establish reasonable rules and regulations to require the administrator of each treatment facility to apply for an order authorizing continued hospitalization of any patient for whom hospitalization is necessary and who was initially hospitalized under an order of a court prior to July 1, 1972. Such prior orders, unless superseded by an order under this part, shall remain valid until July 1, 1973, after which all such orders shall be null and void and of no effect, and every patient retained shall become a voluntary patient unless previously placed on involuntary status pursuant to procedures under this part. Nothing in this part invalidates any order appointing a guardian or determining incompetency.

History.—§11, ch. 71-131.

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394.473 Attorneys' and physicians' fees.—

(1) In case of indigency of any person for whom an attorney is appointed pursuant to the provisions of this part, the attorney shall be entitled to a reasonable fee to be determined by the circuit judge and paid from the general fund of the county from which the patient was hospitalized. In case of indigency of any such person, the court may appoint a public defender. The public defender shall receive no additional compensation other than that usually paid his office.

(2) When any person who previously retained an attorney is adjudged incompetent, the guardian of such incompetent shall be required to pay a reasonable fee to such attorney retained by the incompetent.

(3) In case of indigency of any person for whom the appearance of a physician is required in a court hearing pursuant to the provisions of this act, the physician, except a physician who is classified as a full-time employee of the state or who is receiving remuneration from the state for his time in attendance at the hearing, shall be entitled to a reasonable fee to be determined by the court and paid from the general fund of the county from which the patient was hospitalized.

History.—§13, ch. 71-131; §10, ch. 73-143; §25, ch. 73-334.

394.475 Acceptance, examination, and involuntary hospitalization of Florida residents from out-of-state mental health authorities.—

(1) Upon request of the state mental health authorities of another state, the division is authorized to accept as patients, for a period of not more than fifteen days, persons who are and have been bona fide residents of Florida for a period of not less than one year.

(2) Any person received pursuant to subsection (1) shall be examined by the staff of the state hospital where such patient has been accepted which examination shall be completed during the said fifteen day period.

(3) If upon examination such a person requires continued hospitalization, a petition for

a hearing regarding involuntary hospitalization shall be filed with the circuit judge of the county wherein the treatment facility receiving the patient is located or the county where the patient is a resident.

(4) During the pendency of the examination period herein provided for and the pendency of the involuntary hospitalization proceedings herein provided for, such person may continue to be detained by the treatment facility unless the circuit judge having jurisdiction enters his order to the contrary.

History.—§14, ch. 71-131; §25, ch. 73-334.

394.477 Residence requirements.— No person shall be hospitalized in a treatment facility under the provisions of this part who has not been a bona fide resident of the state continuously for one year immediately preceding his hospitalization. However, any person not a bona fide resident of the state may be hospitalized in a treatment facility pending transfer of said person back to the state of his residence. An indigent nonresident patient shall be transferred to the state of his residence at the expense of the county from which he was hospitalized. The treatment facility, with the approval of the department, shall retain any nonresident who cannot be transferred subject to the provisions of this part.

History.—§15, ch. 71-131.

394.478 Autopsy of deceased patient.—In every case where a person is committed to and received as a patient in the Florida state hospital, and shall die while a patient therein, it is lawful for the superintendent of the Florida state hospital, and he may hold and perform, or cause to be held and performed, an autopsy on such deceased patient, when such deceased patient leaves surviving him no relative or guardian, or when said superintendent shall be unable to communicate with or contact any relative or guardian of such deceased patient for the purpose of procuring consent to such autopsy, and when in the judgment and discretion of the superintendent of the Florida state hospital, such autopsy is in the interest of medical science necessary or desirable.

History.—§1, ch. 19367, 1939; CGL 1940 Supp. 365(311).
Note.—See former §394.19.

During oral argument, Mr. Justice Blackmun requested counsel for Petitioner to submit further information on earlier cases brought by Kenneth Donaldson, as noted at page 1 of the Petition for Writ of Certiorari, page 11 of the Petitioner's Brief, and page 14 of the Reply Brief. Estimates of the number of previous cases vary according to source. Dr. Morton Birnbaum has estimated the number at twelve[1] to eighteen[2]. A search of state files in the possession of various state agencies and courts reveals the following:

(1) Shortly after his commitment in 1957 Kenneth Donaldson wrote a letter to Chief Justice Glenn Terrell of the Florida Supreme Court which was treated as a Petition for Writ of Habeas Corpus and proceeded as *Donaldson v. Rogers*, No. 28-294. The Petition was denied on March 26, 1957. There was no reported opinion.

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1 Birnbaum, *A Rationale for the Right*, 57 Geo.L.J. 752, 775 (1969).

2 Birnbaum, *The Right to Treatment: Some Comments on its Development*, which appeared in *Medical, Moral and Legal Issues in Mental Health Care*, ed. by Ayd, 1974.

(2) The second case began in 1960, again with a letter to the Florida Supreme Court which was treated as a Petition for Writ of Habeas Corpus. The case was styled *Donaldson v. Rogers*. After investigation a Return to the Writ was filed on August 2, 1960, by the Attorney General's Office. The Writ was denied on September 16, 1960, and reported at 123 So.2d 679. This denial was appealed to this Court in *In re Donaldson*, No. 244 Misc. The Petition for Writ of Certiorari was denied on October 10, 1960 and reported at 364 U.S. 808.

(3) Another attempt to seek review by this Court was made in 1962, to *Donaldson v. Florida*, No. 212 Misc., but was denied at 371 U.S. 806.

(4) In early 1963, Donaldson again sought habeas corpus relief in the Florida Supreme Court. The Petition was denied without opinion during July, 1963.

(5) Later in 1963, Donaldson filed a Petition for Writ of Habeas Corpus in Circuit Court in Gadsden County, Florida, on August 28, 1963. The matter was referred, by Circuit Judge Hugh Taylor to County Court with explanation that the Circuit Court had no jurisdiction but Donaldson could seek restoration of competency in the County Court which originally committed him. Donaldson apparently never pursued his remedy in Pinellas County Court. Donaldson appealed this case to the District Court of Appeals for the First District of Florida where the matter was considered

by a three-judge panel, but relief was denied without opinion on September 19, 1963.

(6) The next case appears in 1965. Donaldson filed an original petition for writ of habeas corpus in the Court of Appeals for the Fifth Circuit which was transferred to the Northern District of Florida on April 26, 1965. On April 30, 1965, Judge G. Harrold Carswell ordered the Florida Attorney General to file a response. After due investigation a Response was filed on May 20, 1965. On July 9, 1965, the District Court denied the Petition.

(7) Progress notes of May 1, 1967, in Donaldson's hospital records indicate a petition for writ of habeas corpus. (A 202(b)(i)). However, there are no records of this case.

(8) In 1968, Donaldson filed a Petition for Writ of Certiorari to the Court of Appeals for the Fifth Circuit. This may relate to the previous case. A check of Fifth Circuit records was unsuccessful. This Court denied the Petition, *Donaldson v. O'Connor*, No. 1045 Misc., 390 U.S. 971.

(9) In 1968, Donaldson sought habeas corpus relief in *Donaldson v. O'Connor* filed in Circuit Court in Leon County, Florida. This was transferred to Gadsden County and denied on January 8, 1969. Donaldson appealed to the District Court of Appeals for the First District of Florida. The appeal was dismissed as untimely on May 6, 1969. There was no reported opinion.

This same case was appealed to the Florida Supreme Court on May 12, 1969, where Donaldson was represented by Dr. Morton Birnbaum and the matter was briefed. The appeal was dismissed on November 20, 1969, and reported in *Donaldson v. O'Connor*, 234 So.2d 114.

A Petition for Writ of Certiorari was filed in this Court by Dr. Birnbaum on February 13, 1970, and on October 19, 1970, Certiorari was denied in *Donaldson v. O'Connor*, 400 U.S. 869 (1970).

As noted above, this information was obtained by a search of the records of the United States Court of Appeals for the Fifth Circuit, the United States District Court for the Northern District of Florida, the Florida Supreme Court, the District Court of Appeals for the First District of Florida and the Circuit and County Courts of Leon, Gadsden and Pinellas Counties, Florida.